Montgomery County Department of Health and Human Services
Licensure and Regulatory Services
255 Rockville Pike, Suite 100; Rockville, Maryland 20850
Phone: 240-777-3986 Fax: 240-777-3088
www.montgomerycountymd.gov/licensure

HOSPITAL, NURSING HOME, AND DOMICILIARY LICENSE APPLICATION

TODAY'S DATE: _____

New ☐ Renewal ☐ Change of Owner ☐ Name Change ☐ Bed Increase ☐

Name of Institution: _____ Telephone No. (with area code): _____

Address of Institution: _____
(include street number, suite number, street name, city, state, and zip code)

Fax No: _____ Email: _____

Owner/Corporation Name: _____ Telephone No. (with area code): _____

Address of Owner/Corporation: _____
(include street number, suite number, street name, city, state, and zip code)

Federal Tax Identification No: _____ Former Name of Facility (if applicable): _____

Type of Institution (please check one): Hospital ☐ Nursing Home ☐ Domiciliary Care Home ☐

Type of Care Provided: _____

Bed Capacity (excluding bassinets): _____ Number of Bassinets: _____

Workers' Compensation Insurance Company Name: _____ Policy/Binder No: _____

Check here ☐ if this facility is operated by a sole proprietor with no employees, or by members of a partnership or LLC, and a Certificate of Compliance has been obtained. You must submit a copy of the Certificate of Compliance with this application.

EMERGENCY CONTACT INFORMATION

Director or Administrator: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

*** Montgomery County Department of Health and Human Services must be notified when the emergency contact information changes.

** All New Applicants Must Submit the Use and Occupancy Permit from the Department of Permitting Services (240-777-6240).

I hereby certify that the above information is accurate and complete:

Signature of Owner or Agent: _____

Printed Name and Title of Above Signatory: _____

SEE PAGE 2 FOR PAYMENT INFORMATION

Payment Method: ☐ Check ☐ Money Order ☐ Visa ☐ Mastercard Make checks or money orders payable to "**Montgomery County, Maryland**". Cash is not accepted. Credit card payments may be faxed to 240-777-4531 (confidential fax line).

Fee: $_____ Credit Card No: _____ Exp. Date: _____

Credit Cardholder's Name: _____ Amount Charged: $_____

I agree to pay the indicated total amount according to card issuer agreement:

Cardholder's Signature: _____

FEE SCHEDULE

Type of Facility	Fee
Hospital:……..	$230.00
Nursing Home:……	$12.00/bed
Domiciliary Care Home:……..	$10.00/bed
Late Application Fee - For all applications received after the license expiration date:..…	$100.00

All licenses expire one year after date of issuance.

OFFICE USE ONLY

Receipt No: _____ Date Issued: _____

Amount Paid: _____ Date Expires: _____

Check/Money Order No: _____ Record No: _____

09/09